Related Services Documentation Log

For professional services including PT, OT, Speech, Language & Hearing, Vision, Nutrition, Mental Health Counseling, Rehabilitative Nursing Services.
Not for use with Developmental and Assistive Therapy or Personal Care Services.

STUDENT INFORMATION	**PROVIDER INFORMATION**
Name: **Date of Birth:** **Diagnostic Code:**	**Provider Name:** **Provider Type:** **SU/School:**

Date mm/dd/yy	**Activity/Procedure/Service Brief Description**	**Small Group Or Individual**	**Minutes Per Session**

Group size must be six or less students for professional services or four or less students for paraprofessional services in order to be a Medicaid billable service. Use additional pages as necessary. **DO NOT USE DITTO MARKS, ARROWS, PENCIL or WHITE OUT**.

Actual hours of 1:1 services provided during the billing period	_____ **hours**
Actual hours of small group services provided during the billing period	_____ **hours**

Quarterly progress note to be completed on the back of this form.

Provider Signature: _____ **Date:** _____

Title: _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____